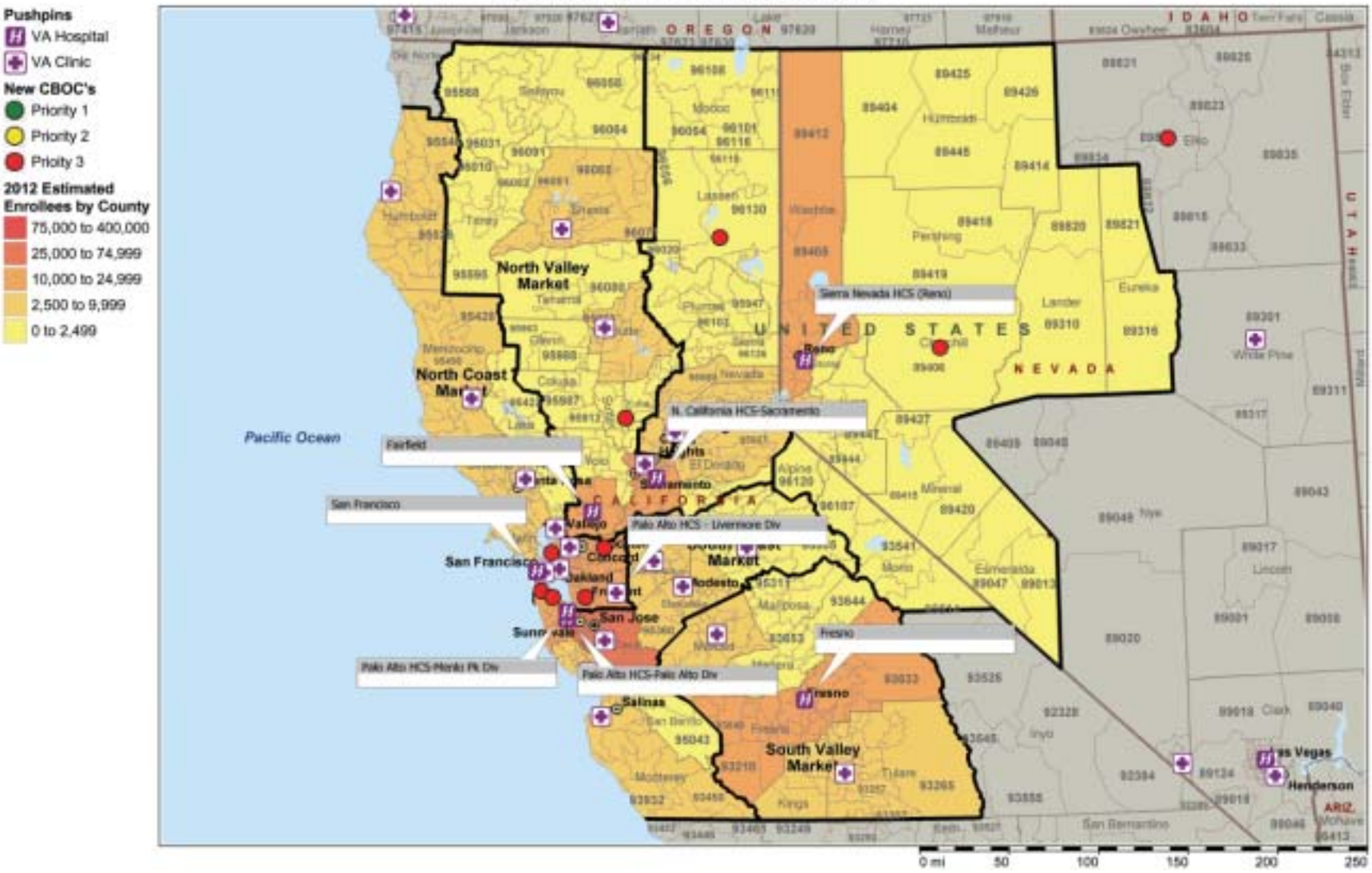
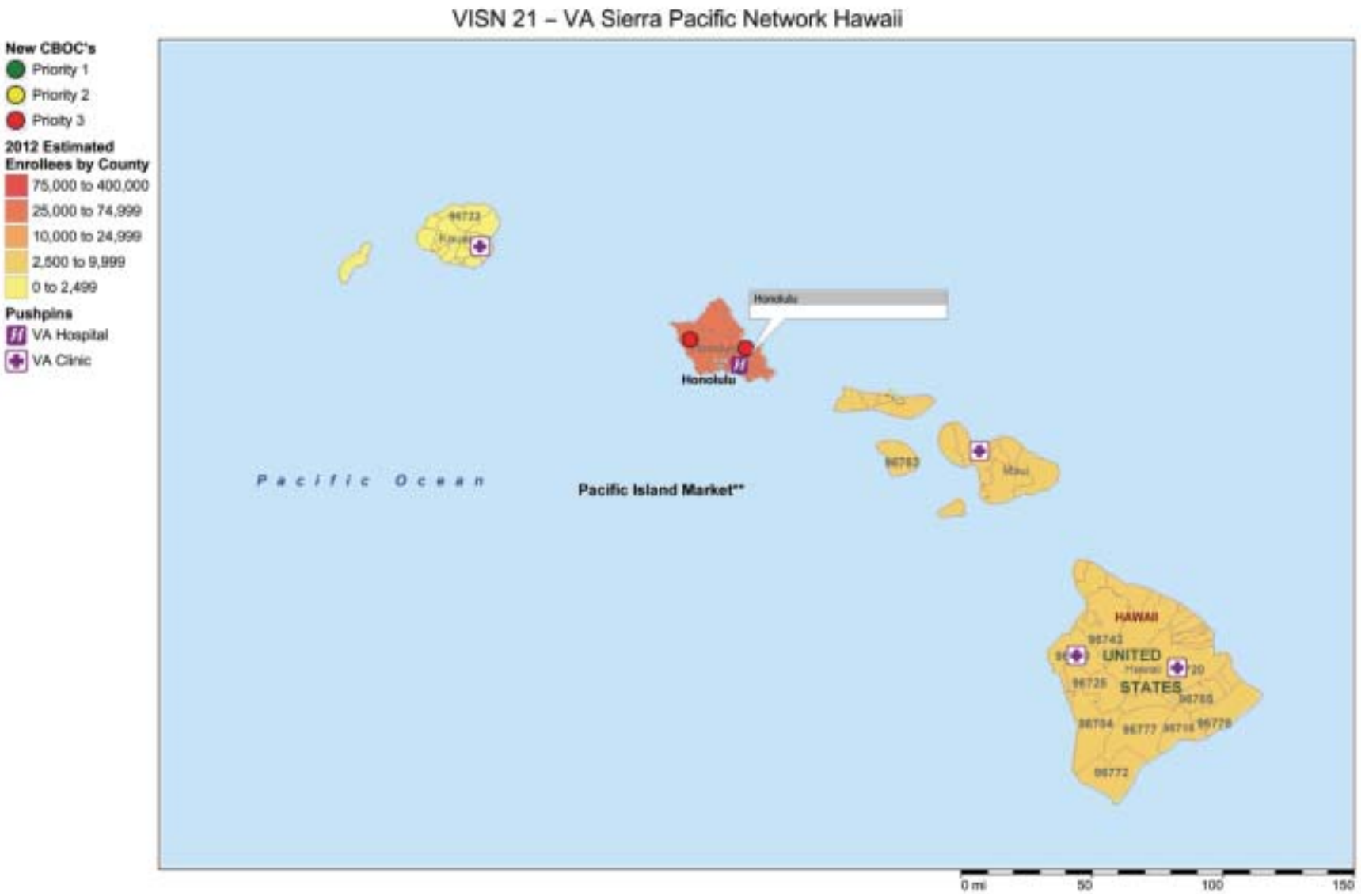
VISN 21 – VA Sierra Pacific Network





VISN 21, Sierra Pacific Network

VISN Overview

VISN 21, Sierra Pacific Network, is an integrated, comprehensive health care system that provided medical services to approximately 188,000 of the 316,000 veterans enrolled in the VISN in FY 2003.[509] Geographically, this VISN spans more than 472,000 square miles. The service area includes central and northern California, northern Nevada, Hawaii, the Philippines, and several Pacific Islands including Guam and American Samoa, and has a total veteran population of 1.2 million. Counties in this VISN range from highly urban to highly rural. VISN 21, with a staff of 7,896 FTEs,[510] delivers health care services through six medical centers, seven nursing homes, 26 community-based outpatient clinics (CBOCs), and a VA CBOC and Regional Office Center (VARO/OC). Additionally, the VA operates 14 Vet Centers in VISN 21's catchment area.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 21.

VISN 21	FY 2001	FY 2012	FY 2022
Enrollees	253,799	257,471	216,224
Veteran Population	1,234,254	936,134	716,508
Market Penetration	20.56%	27.50%	30.18%

For the CARES process, this VISN is divided into six markets: North Coast Market (*facilities:* San Francisco and Martinez, CA); South Coast Market (*facilities:* Palo Alto, Livermore and Menlo Park, CA); North Valley Market (*facility:* Sacramento, CA); South Valley Market (*facility:* Fresno, CA); Sierra Nevada Market (*facility:* Reno, NV); and Pacific Island Market (*facility:* Honolulu-OPC).

[509] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.
[510] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002-September 2003.

Information Gathering

The CARES Commission visited three sites in VISN 21 and conducted one public hearing. The Commission received 961 public comments regarding VISN 21.

- *Site Visits:* Palo Alto Health Care System, which includes Palo Alto, Menlo Park, and Livermore facilities, on July 22 and July 23.
- *Hearing:* Livermore, CA, on October 1.

Summary of CARES Commission Recommendations

I Campus Realignment – Livermore

1. The Commission does not concur with the DNCP proposal that nursing home care at Livermore be transferred to Menlo Park and the community.
2. The Commission recommends that the long-term care (LTC) services (nursing home beds) at Livermore be retained as a freestanding nursing home care unit.
3. The Commission concurs with the DNCP proposal to transfer sub-acute beds to Palo Alto.
4. The Commission concurs with the DNCP proposal to shift outpatient care to CBOCs.

(see page 5-344)

II Inpatient Care and Access

1. The Commission concurs with the DNCP proposal for expansion of services at the Reno VA Medical Center (VAMC) and contracting for services in South Coast and Sierra Nevada markets as needed to meet inpatient access demands.
2. The Commission recommends that:
    a. Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.
    b. VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-346)

III Outpatient Care

1 The Commission recommends that VA open a new CBOC closer to the residences of patients who now receive outpatient care at Livermore.

2 The Commission recommends that:[511]

- a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
- b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
- c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
- d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
- e Whenever feasible, CBOCs provide basic mental health services.
- f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

(see page 5-348)

IV VA/DoD Sharing

1 The Commission concurs with the DNCP proposals on DoD collaborations.

(see page 5-352)

[511] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics* (CBOCs), contains additional information on this topic.

V Infrastructure and Life Safety

1 The Commission concurs with the DNCP proposals for seismic construction projects at facilities in the North Coast, South Coast, and South Valley markets.

2 The Commission recommends that patient and employee safety should be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

(see page 5-354)

VI San Francisco/Palo Alto Consolidation of Services

1 The Commission concurs with the DNCP proposal to maintain both San Francisco and Palo Alto as separate facilities and to realign and consolidate services as the VISN is able to do so.

(see page 5-355)

VII Enhanced Use

1 The Commission concurs with the DNCP proposal to provide a research facility at San Francisco.

(see page 5-357)

Campus Realignment – Livermore

DNCP Proposal

"Current nursing home services will be transferred to Menlo Park campus and contracts in the community. Outpatient services are proposed to transfer from the Livermore campus to an expanded Central Valley CBOC and a new East Bay CBOC closer to where the patients live. Both CBOCs will offer primary care, specialty services and mental health services. VA will no longer operate health care services at this campus. The campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in kind services will remain in the VISN to invest in services for veterans."

DNCP Alternatives

1. *Status quo*
2. *Original Market Plan:* Livermore Division (LVD) largely Status quo. Some primary and specialty care shifted to new East Bay and Central Valley clinics and Palo Alto Division. All NHCU and sub-acute care remains at Livermore.
3. *100 Percent Contracting*
4. *Alternative 1 [The VISN's preferred alternative]:* Consolidate all Livermore programs to other sites (NHCU 80 to Menlo Park, 30 sub-acute to Palo Alto, 52 to contract) new East Bay Clinic; expand Central Valley Clinic, realign some specialty care to PA. Reuse Livermore for EU project consistent with veterans' health needs.
5. *Alternative 2:* Livermore retains NHCU and small primary care and mental only; new East Bay Clinic; Palo Alto absorbs specialty outpatient and 30 sub-acute medicine beds.

Commission Analysis

During the hearing, the Commission received information on the details underlying the realignment proposal. The DNCP recommends transferring Livermore's current services to other VA sites, primarily to Palo Alto, Menlo Park, the new East Bay CBOC, and Central Valley areas as follows:

- Relocate 80 nursing home care unit (NHCU) beds from Livermore to the Menlo Park Division;
- Relocate 30 sub-acute beds from Livermore to the Palo Alto Division;
- Contract for 40 NHCU beds in the community;
- Develop a new, expanded (multi-specialty) San Joaquin Valley CBOC; and

- Develop a new East Bay CBOC.[512]

Information provided at the Livermore hearing by VISN leadership indicates that most of the patients seeking LTC at Livermore are from Modesto (100 miles from Menlo Park), Stockton (in the Livermore area), Livermore, Manteca, and Pleasanton (more than 30 miles away). Lisa Freeman, Director, Palo Alto Health Care System, testified, " There were a total of 180 sub-acute admissions to the Livermore division and 445 long-term care admissions, that's of the 10,407 unique veterans that were treated at the Livermore Division. So admittedly, certainly when you look at the map for those veterans and their families that would have to travel to Menlo Park versus Livermore, that is a disadvantage."[513] Linda Barton, Livermore City Manager, testified:

> A consideration certainly in the Bay Area is if [Livermore services are] relocated, the veterans and their families will have to travel considerable distances in heavy traffic in order to receive service or to visit their relatives from Livermore at Menlo Park. Public transportation is not a very good option for people who are elderly. It would take them at least two and a half hours.[514]

In addition, some stakeholders were concerned about the provision of nursing home services within VA. Bill Lutrell, President of AFGE Local2110, provided a copy of a study prepared for the California Health Care Foundation, "The Financial Health of the California Nursing Home Industry," (May 2003) and stated:

> California's supply of nursing home beds is among the lowest in the country at 31 beds per 1,000, compared to the nationwide ratio of approximately 49 beds per 1,000 elderly. Moreover, there is a striking imbalance in bed supply across counties within the state. This is of great concern as the state's elderly population is projected to grow significantly over the coming decades.[515]

Numerous witnesses testified on the approximately $20 million in renovations that have already been completed at the Livermore nursing home.

The Commission believes a freestanding nursing home should be retained at Livermore, rather than moving its nursing home care to Menlo Park, as most of the nursing home residents come from the Stockton area. Access to care for those veterans and their family members would be negatively impacted, due to travel distance, traffic congestion, and the lack of available public transportation, if the beds were

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[512] Robert Weibe, MD, VISN 21 Director, Written Testimony submitted at the Livermore, CA, Hearing on October 1, 2003, page 8, available from [*http://www.carescommission.va.gov/Documents/LivermorePanel2 Part2.pdf*]

[513] Lisa Freeman, Director, Palo Alto Health Care System, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, pages 74-75.

[514] Linda M. Barton, Livermore City Manager, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, pages 54-55.

[515] Bill Lutrell, President of AFGE Local 2110, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, page 182.

moved. The Commission also discussed the lack of clear evidence on the availability and the quality of care provided in community nursing home beds and the cost that may be associated with those beds. The Commission agrees with the proposal to move 30 sub-acute beds to Palo Alto from Livermore where acute services are available. The Commission also agrees with the CBOCs planned for East Bay and San Joaquin Valley, as this will address outpatient access gaps in the South Coast Market. The proposed location of these clinics is along major highway, which will facilitate improved access to care.

Commission Findings

1. Access to care for some veterans and access for family members of some veterans would be negatively impacted if long-term care beds were moved.
2. There is no clear evidence to determine whether nursing home care beds are available in the community.
3. Palo Alto and Livermore's workload is combined, but data indicate steady increases in nursing home beds and consistent growth in other care services.
4. The Commission received 938 public comments that oppose the closure of Livermore.

Commission Recommendations

1. The Commission does not concur with the DNCP proposal that nursing home care at Livermore be transferred to Menlo Park and the community.
2. The Commission recommends that the LTC services (nursing home beds) at Livermore be retained as a freestanding nursing home care unit.
3. The Commission concurs with the DNCP proposal to transfer sub-acute beds to Palo Alto.
4. The Commission concurs with the DNCP proposal to shift outpatient care to CBOCs.

II Inpatient Care and Access

DNCP Proposals

"*Tertiary Care* – Sierra Nevada Market will expand services at Reno VAMC and contract locally. *Hospital Care* – South Coast Market will contract locally to meet demand and improve access. *Surgery* – Decreasing demand in South Coast Market is being managed by reducing in-house services at Palo Alto. *Psychiatry* – Decreasing demand in South Coast Market is being managed by reducing in-house services."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The Sierra Nevada Market has a gap for access to tertiary care, as only 30 percent of the enrollees in this market are within the tertiary care access guidelines. The Sierra Nevada Market has proposed to address this gap by expanding telemedicine between the Reno VAMC, Palo Alto VAMC, and the San Francisco VAMC and by developing tertiary care contracts within the Reno community.

The DNCP proposal for the South Coast Market to contract for care will allow the market to meet the CARES access-to-hospital standard that requires that 65 percent of veterans be able to reach a hospital in 60 minutes. The South Coast Market's affiliation with Stanford University enables veterans to obtain medical, surgical, and psychiatric treatment. There is a projected decrease of 26 beds in surgery from the FY 2001 baseline by FY 2022 (53 percent below baseline) and a decrease of 41 beds in psychiatry by FY 2022 (34 percent below baseline).[516] The Palo Alto VAMC plans to address these decreases as they materialize by shifting and reducing in-house services. Commissioners note that the South Coast Market has a 50-bed national Post-Traumatic Stress Disorder (PTSD) center, which serves as a resource for PTSD patients nationwide. Thus, 50 of the 112 inpatient psychiatry beds at Palo Alto are from this program, which may not have been taken into account by the CARES projections.

Commission Findings

1. To meet existing tertiary care gaps, the Sierra Nevada Market is expanding its telemedicine capabilities and expanding its community contracts.
2. To meet existing hospital care gaps, the South Coast Market has contracted for care within the community and thus no longer has a gap in this area.
3. Projected decreases in demand for surgical and psychiatric beds will be addressed by shifting and reducing in-house services.

Commission Recommendations

1. The Commission concurs with the DNCP proposal for expansion of services at the Reno VAMC and contracting for services in South Coast and Sierra Nevada markets as needed to meet inpatient access demands.

[516] Appendix D, *Data Tables*, page D-98.

2 The Commission recommends that:

a Before taking action to alter existing VA services, VA must ensure that there are viable alternatives in the community.

b VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

III Outpatient Care

DNCP Proposals:

"*Primary Care* – Increasing primary care demand in all six markets is being met primarily through expansion of existing CBOCs, as well as increasing services at parent facilities. In some cases, expanded hours are planned to increase capacity. A multi-specialty expanded CBOC in the Central Valley and a new CBOC are in the plan as high priorities to meet the outpatient requirements associated with the closure of Livermore. However, since the DNCP attempts to balance meeting national access guidelines, while other access points are included in the DNCP, they are not in the high implementation priority category at this time. *Specialty Care* – Increasing specialty care demand in all six markets is being met by using in-house expansion (new construction, renovation, and leases), utilizing telehealth options for select clinics, and offering selected high volume specialty care service on site at larger CBOCs."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The VISN proposed 12 additional CBOCs in its CARES plan – one new CBOC in the East Bay area in conjunction with the Livermore realignment and 11 new CBOCs to address capacity gaps. In addition, most markets have proposed expansions in outpatient care capacity at existing CBOCs and medical centers. Robert Wiebe, MD, VISN Director, testified:

> The new New East Bay CBOC and the expansion of CBOC services in the Central Valley are critical and our highest priority. These initiatives will directly support the effective realignment of the Livermore campus. The VISN also feels that the establishment of the

> other 11 proposed new CBOCs is essential to meet the increased number of enrollees as projected through the CARES methodology.[517]

None of the new CBOCs were included in the DNCP priority group one.

According to CARES planning data, the North Valley Market, Sierra Nevada Market, North Coast Market, and the South Coast Market will have shortfalls in both primary and specialty care in FY 2012, with these gaps projected to decrease by FY 2022. For the North Valley Market, primary and specialty care are projected to increase by 16 percent and 44 percent over the FY 2001 baseline by 2012, respectively. The Sierra Nevada Market is projected to have an increase in demand for primary and specialty care of 26 and 42 percent over baseline, respectively. For the North Coast Market, these figures are 63 and 32 percent over baseline, respectively. For the South Coast Market, projections are 42 and 46 percent over baseline, respectively, for these types of care. These projections decrease by FY 2022 in all markets.[518] To address these shortfalls, the VISN proposed expansion of existing and additional CBOCs as well as the expanded use of telemedicine.

The primary care workload is projected to increase by 67 percent over baseline by FY 2012 for the Pacific Islands Market with a gradual decline in demand of 46 percent over baseline by FY 2022, and this market's specialty care workload demand is projected to increase by 212 percent over baseline by FY 2012, with a very slight decline to 192 percent by FY 2022.[519] The market proposal included expanding the existing CBOCs on the neighbor islands of Hawaii, establishing three new CBOCs at Kaneohe and Waianae on Oahu and in American Samoa, expansion of the joint venture at Tripler Army Medical Center/VAMC Honolulu to provide an ambulatory surgical and invasive procedure suite, and expanding the CBOC capacity in Guam through participation in a VA/DoD joint venture with the Navy.

Congressman Eni Faleomavaega testified:

> According to a survey conducted by U.S. Army Reserve during a four-month period in 2001, 2 years ago, American Samoa now has over 5,000 veterans, although only 1,000 are registered in the Veterans Administration due the lack of information by the administration process. American Samoa also has 19,806 military dependents. American Samoa's total population is approximately 60,000. About 20,000 of these residents are foreign and, of a native population of 40,000, approximately 15,000 are under the age of 18. This means that roughly 25,000 U.S. Nationals and citizens over the age of 18

[517] Robert Weibe, MD, VISN 21 Director, Written Testimony submitted at the Livermore, CA, Hearing on October 1, 2003, page 5, available from [*http://www.carescommission.va.gov/Documents/LivermorePanel2 Part1.pdf*].
[518] Appendix D, *Data Tables*, page D-99.
[519] Appendix D, *Data Tables*, page D-99.

> live in American Samoa, and of this number, 5,000 are veterans. … many should qualify for VA services.[520]

H. David Burge, Director of the VA Pacific Islands Health Care System, testified that determining the number of veterans in American Samoa has been problematic. Though the census indicates that there are about 1,000 veterans, when VA sent a team to do a count, it found the number to be about 800. Mr. Burge indicated that, of the 800, most would be high users, but recognized that this population would not meet the threshold for a CBOC. He indicated that they are trying to build a critical mass by working with DoD and the Army Reserves. VA is currently negotiating with the Army Reserves for it to give VA a building. With construction costs of a little more than $1 million, the building could be converted to a clinic that would serve DoD beneficiaries as well as veterans.[521]

Congresswoman Madeleine Bordallo testified concerning the veterans of Guam:

> I am also concerned that like other facilities dependent on the Department of Defense, construction in Guam will be delayed, causing the 2008 time frame to slip. While I am deeply grateful that this project is designated as a "high priority" under the Draft National Plan, I am not aware of how the VA can hold the Navy firm to the 2008 timeline.[522]

Dr. Weibe, VISN Director, testified, "It's not a new CBOC, but again, working with the Department of Defense to maintain a clinic on the naval site in Guam is high priority."[523]

Commission Findings

1. The VISN proposed 12 additional CBOCs in its plan, one of which was to address the proposed mission change at Livermore. None of the 11 new CBOCs is in the DNCP's priority group one.
2. Four of the markets had projected increases in demand in both specialty and primary care by FY 2012, with declining demand for both areas by FY 2022.
3. The Pacific Islands Market expects an increase in primary care demand by FY 2012, with a decrease in demand by FY 2022. Specialty care in this market significantly increases in FY 2012, and there is only a slight decrease by FY 2022.

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[520] The Honorable, Eni F.H. Faleomavaega, Congressman, American Samoa, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, page 24-25.

[521] H. David Burge, Director, VA Pacific Islands Health Care System, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, page 80.

[522] The Honorable Madeleine Z. Bordallo, Congresswoman, California, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, page 18.

[523] Robert L. Weibe, MD, VISN 21 Director, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, page 83.

4 Though the veteran population on American Samoa does not appear to meet the threshold for a CBOC, the Director of the Pacific Island HCS is moving forward with a possible joint venture with the Army Reserves.

5 The Guam CBOC is a high priority for the VISN. The VISN will continue to work with DoD for inclusion of a new clinic in the DoD replacement hospital.

6 The South Valley Market projects an increased demand in specialty care in FY 2012, with this demand diminishing over the next 10 years.

Commission Recommendations

1 The Commission recommends that VA open a new CBOC closer to the residences of patients who now receive outpatient care at Livermore.

2 The Commission recommends that:[524]

- a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.
- b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.
- c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.
- d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.
- e Whenever feasible, CBOCs provide basic mental health services.
- f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

[524] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics* (CBOCs), contains additional information on this topic.

IV VA/DoD Sharing

DNCP Proposal

"The VISN is developing the following collaborative opportunities with DoD: In Pacific Island Market, enhancing access to tertiary and acute care and to meet primary and specialty care outpatient needs through expanded agreements with Tripler Army Medical Center. There may be opportunities of collaboration in medical research with DoD in Hawaii, particularly given DoD's anticipation of a new research facility on Oahu. In addition, there are opportunities with DoD in the North Valley Market at Travis AFB to provide enhanced access to inpatient care, primary care, and specialty care. Also working with DoD on joint ventures for both inpatient and outpatient care in Monterey."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The Sierra Pacific Network is actively engaged in DoD collaborative initiatives in four of the six markets. Several of these collaborative efforts have been ongoing for years and are associated with large and successful VA/DoD sharing agreements.

The joint venture with Air Force's David Grant Medical Center (DGMC) at Travis AFB in Fairfield, CA, is well established. This venture currently provides veterans with 24-hour emergency care, specialty care service for selected diagnostic procedures, and inpatient hospitalization. VA also has an outpatient clinic on the DGMC campus. Under discussion are plans to provide an inpatient psychiatry unit as well as the feasibility of opening a DoD-operated joint pharmacy at the VA Sacramento outpatient clinic.

Colonel James Collier, MC, testified:

> We feel our unique position as a well-manned graduate medical training center gives us excess capacity in several medical and surgical specialties that may allow us to help with any increase in specialty care needs resulting from the increased access the VA proposes through this plan, so, to summarize my opinion: Region 10, we greatly support the CARES initiatives for the North Coast and the South Coast.[525]

[525] Colonel James Collier, MC, Region 10, TRICARE Lead Agent, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, pages 156-157.

Colonel James Meyers further testified:

> Medical treatment facility (MTF) Commanders will receive three types of funding: funds for readiness operations, funds for other operations, like Graduate Medical Education, and a capitated fund allocation based on the MTF's enrolled population. While the details are still being worked out, the basic concept is fixed, an MTF Commander will pay for all care provided to her enrolled population, whether provided in-house, by the health service and support contact or, most importantly for this discussion, provided by any other source to include the VA. We believe this is one more great reason to collaborate with the VA.[526]

The Pacific Island Market has a joint venture between the Honolulu VA and Tripler Army Medical Center. Current plans call for a new joint-use ambulatory surgical center and specialty clinic pavilion and to integrate and expand research through a new clinical research center. Plans also include an addition to an existing parking structure. This VISN will participate as a demonstration site for budget and financial management as mandated by the Fiscal Year 2003 National Defense Authorization Act. Colonel Frederick Gargiulo, Chief of Staff for Tripler Army Medical Center, testified:

> The project would include structure and processes to jointly assess, execute, and evaluate health care forecasting demand management and resource tracking, coordinated referral management, fee authorization, revenue management utilizing a joint charge description master and document management. The most exciting aspect of this proposal is that these products will be designed in such a way that they would be exportable to other VA/DoD collaborative sites.[527]

In Guam, VA is working to include a VA outpatient clinic at the Navy's replacement hospital.[528] In American Samoa, VA is working to obtain an Army Reserves building that VA would convert to an outpatient clinic that would serve VA and DoD beneficiaries.

Commission Findings

1. The Sierra Pacific Network has several large, successful, existing VA/DoD sharing agreements.
2. VA has an outpatient clinic on the DGMC campus and is exploring the feasibility of expanding this sharing agreement to include inpatient psychiatry and a joint pharmacy at the VA Sacramento Outpatient Clinic.

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[526] Colonel James Meyers, Region 10, TRICARE Executive Director, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, page 159.

[527] Colonel Frederick Gargiulo, Chief of Staff, Tripler Army Medical Center, Transcribed Testimony from the Livermore, CA, Hearing on October 2003, page 150.

[528] Appendix I, page 4, of the DNCP.

3. Tripler Army Medical Center and VA Pacific Islands Health Care System, Hawaii have been selected to be one of the demonstration sites for budget and financial management by the DoD/VA Health Executive Council.
4. A VA outpatient clinic is proposed at the Navy's replacement hospital in Guam.
5. In American Samoa, VA is proposing to build an outpatient clinic to be used by both VA and DoD beneficiaries.

Commission Recommendation

The Commission concurs with the DNCP proposals on DoD collaborations.

V Infrastructure and Life Safety

DNCP Proposal

"The VISN has proposed seismic construction projects at facilities in the North Coast, South Coast, and South Valley markets, including VA facilities in Palo Alto, San Francisco, Menlo Park, and Fresno."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The North Coast Market has six buildings with seismic construction projects from the Exceptionally High Risk list – the main acute inpatient hospital at San Francisco; four buildings that house specialty clinics, administration, and research; and the Martinez division, which has a seismic construction project for its laboratory and research building.

The South Coast Market's psychiatry building, research, and the gero-psychiatric nursing home care building are on the VA Exceptionally High Risk seismic inventory list.

The South Valley Market has five buildings with seismic issues. The buildings are currently used for a mixture of outpatient mental health and administrative functions. Two of the buildings are on the VA seismic list; three are not because they are not used for patient care.

At the Livermore hearing, the VISN Director testified, "The Network has identified $196 million in seismic correction major and minor construction projects, which include the three top seismic risk projects on the VA's exceptionally high risk listing. Correction of these seismic deficiencies is seen as the top priority in the Network."[529]

Commission Finding

Construction to correct seismic deficiencies is needed at Fresno, San Francisco, Martinez, Palo Alto, and Menlo Park.

Commission Recommendations

1. The Commission concurs with the DNCP proposals for seismic construction projects at facilities in the North Coast, South Coast, and South Valley Markets.
2. The Commission recommends that patient and employee safety should be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

VI San Francisco/Palo Alto Consolidation of Services

DNCP Proposal

"Services to be consolidated at San Francisco include the following: *Administrative Services:* Reproduction services (i.e., copies) and HR classification. *Clinical Services:* Parkinson's disease and epilepsy surgery and brain mapping, potions of neurosurgery including stereotactic radiosurgery (including Gamma Knife), Brainstem auditory evoked responses, Somato sensory evoked potentials, All surgery requiring intra-operative spinal cord and root monitoring, electronystagmographs, bachytherapy for prostate cancer, endovascular, embolism of AVM, Hohs surgery, portions of radiology including neuroradiology through increased use of PACS, all dental surgery including dental implantology, and portions of laboratory services.

Services to be consolidated at Palo Alto include the following: *Administrative Services:* Warehousing opera tions, disposal of government property program, recycling program, management of grounds and transportation services, prosthetics and sensory aids purchasing agents, IRM help desk and police training. *Clinical Services:* Long-term inpatient care for dementia, neurobehavioral problems and substance abuse, electroconvulsive therapy (ECT), long-term care for chronically mentally ill, and selected laboratory contract testing."

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[529] Robert Weibe, MD, VISN 21 Director, Written Testimony submitted at the Livermore, CA, Hearing on October 1, 2003, page 4, available from [*http://www.carescommission.va.gov/Documents/LivermorePanel2 Part1.pdf*].

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

As part of the CARES process, VAMCs in close proximity (within 60 miles) were required to evaluate whether their services could be consolidated. VISN 21 is supported by two tertiary care facilities, San Francisco and Palo Alto, which are within 40 miles of one another. Both are highly affiliated medical centers: San Francisco is affiliated with the University of California, San Francisco, and Palo Alto is affiliated with Stanford University. Both of these sites serve as referral centers for other facilities within the VISN, and consolidation of most clinical programs into a single site would be impractical. Some consolidation of services has already occurred – primarily in highly specialized, low-volume, high-cost clinical services and for selected administrative functions. A review of the CARES space data indicates that neither facility would have the ability to absorb the workload of the other and that both have several seismically unsafe buildings on the Extremely High Risk list.

The VISN Director, Dr. Robert Weibe, testified that after a comprehensive analysis of the two facilities, "We concluded that it is not feasible or desirable to close or fully consolidate either site. We based this on the surrounding veteran population, historical referral patters, capacity of each facility and the critical role each facility plays."[530]

Commission Findings

1. If San Francisco and Palo Alto were to consolidate into one medical center, there would be the only one tertiary care site available for both the North Coast and South Coast Markets. Although they are only 40 miles from one another, they are located in a highly urban, congested setting.
2. If the two facilities were to consolidate into one medical center, it is likely a gap in access to hospital care would be created.
3. Neither VAMC has the capacity to absorb the workload of the other.

Commission Recommendation

The Commission concurs with the DNCP proposal to maintain both San Francisco and Palo Alto as separate facilities and to realign and consolidate services as the VISN is able to do so.

[530] Robert Weibe, MD, VISN 21 Director, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, page 64.

VII Enhanced Use

DNCP Proposal

"Proposals are being developed involving research at San Francisco and long-term care at Sacramento. Joint venture for ambulatory and long-term care with Alameda County and assisted living facility at the Menlo Park Division of Palo Alto Health Care System."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The VISN Director, Dr. Robert Weibe, testified that there are several new enhanced use leasing (EUL) projects designed to further the VISN's long-term care and research programs. One of these projects is a 100-bed LTC facility on the campus of the new VA medical center in Sacramento, CA. This project at Sacramento is on hold awaiting resolution of the Department's assisted living policy.

Another project is an EUL project at the San Francisco VAMC, which will provide critically needed research space.[531] The proposed EUL project would provide for a new 200,000 square foot research facility and a parking structure. The VISN is awaiting approval from VA Central Office. The project is anticipated for completion by FY 2007.

Commission Finding

The proposed EUL projects are in the early- to mid-planning stages.

Commission Recommendations

1 The Commission concurs with the DNCP proposal to provide a research facility at San Francisco.

[531] Robert Weibe, MD, VISN 21 Director, Transcribed Testimony from the Livermore, CA, Hearing on October 1, 2003, page 66.